Concussion Service

Operational Guidelines

This guide is to be read in conjunction with ACC’s Standard Terms and Conditions and the Concussion Service Specification

July 2018
Version 1

This is a living document and will be updated as required – the latest version is available on https://www.acc.co.nz/for-providers/
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1. **Introduction to Concussion Services**

Concussion is the most common type of Traumatic Brain Injury (TBI) and refers to mild to moderate TBIs (MTBI). MTBI is a technical term used more commonly in general medical contexts. However, the term ‘concussion’ is still commonly used in sports medicine and is used here to describe this service.

Concussion is frequently defined as a head injury with brief loss of brain function and can also cause physical, cognitive, and emotional symptoms. There does not have to be an observed loss of consciousness.

The Concussion Service is based on rehabilitation best practice and recognises the bio-psycho-social model. The service works holistically and is flexible to best meet the rehabilitation needs of the Client while recognising the legal responsibilities of ACC and the Supplier.

The Concussion Service (CS) is an interdisciplinary service consisting of triage, assessments and therapy to support Clients to recover from a mild to moderate traumatic brain injury and return to everyday life. The Concussion Service also aims to prevent long-term consequences by identifying Clients at risk of persisting symptoms and providing them with effective interventions and education. Education is also provided to clients to reduce the incidence of re-injury.

2. **Purpose**

The purpose of the service is to:

- Support Clients’ recovery and prompt return to their everyday life, including work or school;
- Reduce the incidence of long term consequences, such as persisting concussion symptoms, by identifying Clients likely to develop long term consequences and provide them with effective interventions and education.
- Reduce the incidence of further brain injury by providing Clients with education about traumatic brain injury

3. **Philosophy**

The Concussion Service has three core philosophies.

**3.1. Individual needs**

Each person who sustains a brain injury responds differently, therefore their assessment and rehabilitation needs can vary. ACC and Suppliers will adapt services to ensure the services are tailored to meet the needs of the individual client.

**3.2. Interdisciplinary team**

The Concussion Service is provided by an interdisciplinary team specialising in treating Clients with mild to moderate traumatic brain injuries. The service includes assessments and treatments to help Clients achieve long-term recovery so that they no longer require services under this contract. The full interdisciplinary team participates throughout with the key worker/co-ordinator ensuring that services are co-ordinated. Regular group meetings are held to discuss the Client’s rehabilitation progress and to identify the Client’s on-going rehabilitation needs.
3.3. Relationships

ACC and Suppliers work together to support the Client’s rehabilitation. This is achieved by maintaining close working ties through good communication, respecting each other’s areas of expertise, and fully engaging the Clients and their family/whānau in the recovery process. Strong working relationships are also maintained with community service providers and other health professionals to ensure the Client is supported to achieve independence.

4. Service objectives

ACC will measure the success of this service based on the following objectives:

- Clients are returned to their usual activities of everyday life, including work or school, and no longer require any continued support from the Concussion Service for their brain injury

- Clients who are likely to develop long term consequences of their brain injury are identified early and provided with effective interventions and education about traumatic brain injury

- Clients receive education to help prevent the incidence of successive brain injuries

- Clients report overall satisfaction with the services provided.

- Services are provided in the shortest timeframe and at the lowest cost while maintaining clinical appropriateness

5. Useful contact numbers

<table>
<thead>
<tr>
<th>Who to contact</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC Supplier Helpline</td>
<td>0800 222 070</td>
<td><a href="mailto:providerhelp@acc.co.nz">providerhelp@acc.co.nz</a></td>
</tr>
<tr>
<td>ACC Client/Patient Helpline</td>
<td>0800 101 996</td>
<td></td>
</tr>
<tr>
<td>Supplier Registration</td>
<td>04) 560 5211</td>
<td><a href="mailto:registrations@acc.co.nz">registrations@acc.co.nz</a></td>
</tr>
<tr>
<td>ACC eBusiness</td>
<td>0800 222 994</td>
<td><a href="mailto:ebusinessinfo@acc.co.nz">ebusinessinfo@acc.co.nz</a></td>
</tr>
<tr>
<td>Health Procurement</td>
<td>0800 400 503</td>
<td><a href="mailto:health.procurement@acc.co.nz">health.procurement@acc.co.nz</a></td>
</tr>
<tr>
<td>If you have a question about your contract or need to update your details, please contact the ACC Health Procurement team.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engagement and Performance Managers</td>
<td>Engagement and Performance Managers can help you to provide the services outlined in your contract. Contact the Supplier Helpline or click on the link provided here for details of the EPMs in your region. Contact an Engagement and Performance Manager</td>
<td></td>
</tr>
<tr>
<td>ACC Concussion Service Portfolio Advisor</td>
<td>Contact the Supplier Helpline for details of the Portfolio Advisor</td>
<td></td>
</tr>
</tbody>
</table>
Please report all health, safety and security risks or incidents in writing using the procedure on our website [https://www.acc.co.nz/for-providers/report-health-safety-incidents](https://www.acc.co.nz/for-providers/report-health-safety-incidents)

6. **Concussion Service Forms**

All Concussion Service forms are available on the [https://www.acc.co.nz/resources](https://www.acc.co.nz/resources) page by searching the form number using the search function.

- ACC883 Concussion Service Referral Form
- ACC7412 Concussion Service child or adolescent referral
- ACC884 Concussion Service Client Summary Form
- ACC885 Concussion Services Did Not Attend report
- ACC886 – Concussion Services Outcome Report

7. **Responsibilities**

7.1. **Supplier responsibilities**

The Supplier is responsible:

<table>
<thead>
<tr>
<th>to...</th>
<th>for...</th>
</tr>
</thead>
</table>
| Clients| • Ensuring the education, triage, assessment, therapy and rehabilitation provided is appropriate to the diagnosis  
• Providing services promptly, for example:  
  - holding the first appointment within 5 business days of the referral being received  
• Encouraging the Client’s self-management and active participation in the rehabilitation process  
• Providing high quality assessments and treatment services  
• Ensuring the interdisciplinary team works together throughout the service delivery to the Client  
• Delivering services only when clinically necessary  
• Including the Client’s family and whānau, where appropriate |
| ACC    | • Nominating a key worker/coordinator to be the primary contact with ACC  
• Ensuring the Client has a confirmed diagnosis prior to commencing therapy by  
  - investigating up to 5 years’ of prior clinical notes relating to the claim  
  - conducting clinical case reviews to identify assessment needs  
• Conducting the appropriate clinical assessments to confirm the diagnosis as |
<table>
<thead>
<tr>
<th>to...</th>
<th>for...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requested</td>
<td>Working within timeframes outlined in the service specification or as agreed with the Case Owner, including:</td>
</tr>
<tr>
<td></td>
<td>- conducting a Client needs assessment</td>
</tr>
<tr>
<td></td>
<td>- submitting reports</td>
</tr>
<tr>
<td></td>
<td>- acting in a timely way to maximise the Client’s rehabilitation outcome</td>
</tr>
<tr>
<td></td>
<td>Demonstrating commitment to the contracted outcome by completing section 12 of the ACC884 Client Summary</td>
</tr>
<tr>
<td></td>
<td>Maintaining contact with the Case Owner (as agreed) to discuss changes or developments, e.g. change in symptoms, work readiness, living situation, family, or financial issues etc., to help ACC support the Client</td>
</tr>
<tr>
<td></td>
<td>Giving ACC a copy of any clinical information provided to or collected from the GP relevant to the Client’s TBI</td>
</tr>
<tr>
<td></td>
<td>Maintaining high quality clinical notes which:</td>
</tr>
<tr>
<td></td>
<td>- support and verify any risk assessment and/or ACC884 Client Summary form information</td>
</tr>
<tr>
<td></td>
<td>- aid decision-making for ACC and other Suppliers as appropriate</td>
</tr>
<tr>
<td></td>
<td>Operating the service within the terms and principles of the Concussion Service contract and these Operational Guidelines</td>
</tr>
<tr>
<td></td>
<td>Attending Supplier Days for purposes of training, quality improvement, service delivery enhancements and performance discussions.</td>
</tr>
</tbody>
</table>

| Referrers (GPs) | Providing timely and relevant clinical information to support the overall care of the Client, such as: |
| | - assessment and treatment programmes including medication |
| | - rehabilitation plans for return to work |
| | Recommending return to work time frames |

| Other service Suppliers | Maintaining good working relationships based on respect for each other’s area of focus |
| | Providing and receiving information appropriate to the situation and need. |
### 7.2. Client responsibilities

The Client is responsible

<table>
<thead>
<tr>
<th>to...</th>
<th>for...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suppliers</td>
<td>• Attending appointments or rescheduling them with reasonable notice, when they are unable to attend</td>
</tr>
<tr>
<td>Suppliers and ACC</td>
<td>• Participating in the rehabilitation process</td>
</tr>
<tr>
<td></td>
<td>• Discussing any problems that may hinder their recovery with their ACC Case Owner and Supplier.</td>
</tr>
</tbody>
</table>

### 7.3. ACC responsibilities

ACC is responsible:

<table>
<thead>
<tr>
<th>to...</th>
<th>for...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clients</td>
<td>• Ensuring Clients have the correct diagnosis and cover decision</td>
</tr>
<tr>
<td></td>
<td>• Ensuring they get the appropriate services and support to help them rehabilitate and return to everyday life, including work or school</td>
</tr>
<tr>
<td></td>
<td>• Making timely, efficient, and effective decisions</td>
</tr>
<tr>
<td>Suppliers</td>
<td>• Making prompt decisions based on the available information or, if the information is unavailable, investigating as appropriate</td>
</tr>
<tr>
<td></td>
<td>• Working with the Supplier to rehabilitate the Client</td>
</tr>
<tr>
<td></td>
<td>• Agreeing new timeframes where the Client’s needs cannot be addressed within the existing timeframe</td>
</tr>
<tr>
<td></td>
<td>• Keeping them up to date regarding</td>
</tr>
<tr>
<td></td>
<td>- any other assigned service Suppliers such as vocational services</td>
</tr>
<tr>
<td></td>
<td>- who the lead Supplier is where services need to be coordinated</td>
</tr>
<tr>
<td></td>
<td>- any delays or issues that may impact on service provision</td>
</tr>
<tr>
<td></td>
<td>• Following up with the Supplier if they have not been in touch as agreed</td>
</tr>
<tr>
<td></td>
<td>• Seeking clarification from the Supplier if progress and outcomes are not being achieved</td>
</tr>
<tr>
<td>Referrers (GPs)</td>
<td>• Confirming the acceptance or decline of the referral</td>
</tr>
<tr>
<td></td>
<td>• Keeping the GP informed of the Client’s progress</td>
</tr>
</tbody>
</table>
Employers

- Keeping Employers up to date with the Client’s rehabilitation process and encouraging them to keep the Client’s job available for a successful return to employment

Other services Suppliers, eg Vocational Rehabilitation Providers

- Keeping them informed of any relevant information for coordinating the rehabilitation process.

8. Communication protocols

8.1. Relationship expectations

The rehabilitation partnership between the Supplier and the Case Owner is one of the most important tools for ensuring the recovery of the Client. Having the Supplier and Case Owner working and communicating collaboratively will help with the Client’s rehabilitation.

There is an expectation that:

- Suppliers and ACC Case Owners will work together to assist in the Client’s rehabilitation
- Both parties will respect each other’s area of expertise
- Suppliers are experts in the rehabilitation of brain-injured Clients and are responsible for achieving the service outcome for the Client within the context of the Service (as defined in the service specification)
- ACC Case Owners are expert at managing the complex mix of rehabilitation, entitlements, and compliance relating to claims
- ACC is responsible for funding rehabilitation services as necessary and appropriate.

The Supplier will nominate a key worker/coordinator to have contact with ACC. The key worker/coordinator will:

- Keep ACC informed of any issues regarding the provision of assessments or treatment
- Raise any issues with the service and suggest solutions
- Ensure all services are carried out in accordance with the service schedule and this operational guideline.
- Represent the Supplier in service performance discussions
- Inform ACC promptly when any contact details change.

8.2. Communicating instead of reporting

Formal written clinical reports are not purchased in this service. The assessments determine the Client’s requirements for the Concussion Service and are not intended to determine cover or entitlement, although they may be used to confirm diagnosis. Instead, Suppliers are asked to convey to the ACC Case Owner information that supports appropriate fact-based decision-making. Suppliers may choose to provide further information at their own discretion.
A summary of the neuropsychological assessment screen report must be shared with the Interdisciplinary Team and submitted to ACC. This report is expected to be brief and forms part of the five hours allocated for the Neuropsychological Screen.

Where a diagnosis is very complex and a separate report is required, ACC may choose to purchase this separately. This does not form part of the CS spend. This will be purchased at the standard hourly rate under the service item codes MEDR.

The reporting structure in the Concussion Service highlights the importance of effective communication between ACC Case Owners and the Supplier. Phone calls and emails should cover the following topics:

- The Client’s current status
- The potential recovery timeframe and plan
- The impact of other issues on the Client
- Any recommendations or needs the Supplier may have

9. **Service End to End Process**

The key to the Concussion Service is the flexibility to adapt to the needs of the Client while remaining efficient and effective.

The referral, assessment, triage and therapy sections shown in the process map are not rigid or inflexible. The discussion and agreement between the Supplier and ACC determines the appropriate route for the Client.
Process Map 1 showing the client’s pathway through the Concussion Service:

**Referral**
- Referral from GPs or A&M clinics
- Referral from Medical or Allied Health Staff at DHB
- Referral generated by ACC

**Supplier Confirms Diagnosis**
1. Collect clinical notes and interview client
2. Identify what further assessments are required to confirm the diagnosis via IDT
3. Discuss with ACC to agree purchase order
4. Conduct the approved consultations to confirm diagnosis such as:
   - medical specialist and/or
   - clinical neuropsychologist or
   - allied health or
   - other specialist

- Unconfirmed diagnosis
- TBI Diagnosis confirmed
- End

**Assessment** (if not already assessed)
- ACC884 Client Summary Supplier Recommendation

**Supplier Assesses the Client’s Need**
1. Collects clinical notes, interviews client and drafts summary
2. Conduct Med Spec & Clin Psych triage case reviews
3. IDT identifies what other assessments are needed to assess the Client’s needs (allied health, other specialists)
4. Conducts the required assessments
5. Develops rehabilitation plan
6. Prepare ACC884 Client Summary

**Triage**
- ACC
- Not Recovered
  - Low needs
  - Stay in CSS
- Not Recovered
  - Non-Concussion Needs
- Not Recovered
  - Too complicated
  - Exit CSS
- Recovered
- Recommend Other Services
  - The case owner selects other ACC treatment and rehabilitation services such as Vocational Services to work alongside CSS
- Recommend Complex Services
  - The case manager selects other ACC treatment or rehabilitation services such as:
    - Neuropsychological Assessment Services
    - Clinical Services
    - Training for Independence
    - Psychological Counselling Services
    - Physiotherapy

**Therapy**
- Delivery Therapy Services
  - Psychological Counselling
  - Medical Consultation
  - Allied Health Services
9.1. Service Item Codes

Table 1 - Using service item codes for the different activities in the service.

<table>
<thead>
<tr>
<th>Service</th>
<th>Activity Group</th>
<th>Service Item Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigate &amp; triage</td>
<td>Education, risk assessment</td>
<td>TBI21 – Education, assessment of risks to recovery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TBI13 – Clinical neuropsychologist case review</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TBI14 – Medical Specialist case review</td>
</tr>
<tr>
<td>Investigate &amp; triage</td>
<td>Clinical Assessments</td>
<td>TBI22 – Allied health Client assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TBI23 - Clinical neuropsychologist Client assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TBI30 – Medical Specialist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TBI25 – Other clinical assessment</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>Therapy</td>
<td>TBI26 – Allied health therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TBI27 – Psychologist consultation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TBI28 – Medical Specialist consultation</td>
</tr>
<tr>
<td>Administration</td>
<td>Triage, Assessment and Therapy</td>
<td>TBI29 – Key worker/coordinator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TBIDNA – Non-attendance fee</td>
</tr>
</tbody>
</table>

10. Client eligibility

To be referred to the Concussion Service, the Client must meet all of the following criteria:

Table 2 - Client eligibility criteria

<table>
<thead>
<tr>
<th>Client must...</th>
<th>and</th>
<th>and</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have sustained a TBI (or suspected TBI) within the previous 12 months</td>
<td>Has at least one of the following on-going signs and symptoms such as:</td>
<td>Have at least one of the additional risk factors such as:</td>
</tr>
<tr>
<td>Have an accepted ACC claim, and</td>
<td>• mood changes</td>
<td>• the inability to work or attend school for more than one week</td>
</tr>
<tr>
<td>be diagnosed with or</td>
<td>• memory problems</td>
<td>• second or subsequent MTBI within six months</td>
</tr>
<tr>
<td>be suspected of having a mild TBI, moderate TBI or</td>
<td>• fatigue</td>
<td>• post traumatic amnesia lasting more than 12 hours</td>
</tr>
</tbody>
</table>
Client must... and and

- persisting concussion symptoms • headaches
  • visual disturbances
  • nausea
  • muscular aches
  • dizziness
- a requirement to operate machinery or drive at work
- a pre-existing psychiatric disorder or substance abuse problem
- a high functioning job such as engineer, medical practitioner or lawyer
- currently attending secondary or tertiary education

### 10.1. Clinical diagnosis - severity of injury

Clients diagnosed with a mild or moderate traumatic brain injury (TBI) are suitable for the Concussion Service. Clients with a moderate TBI with complex needs who remain in the Concussion Service may experience multiple assessments (some assessments should not be completed within a 12 month period) and delays in their recovery. These Clients may be more appropriately referred to other services eg:

- Clinical Services
- Neuropsychology Service
- Training for Independence

Table 3 - Used to categorise the severity of the TBI at the acute stage.

<table>
<thead>
<tr>
<th>Severity of injury</th>
<th>Glasgow Coma Scale (GCS)</th>
<th>Duration of Post-Traumatic Amnesia (PTA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>13-15</td>
<td>less than 24 hours</td>
</tr>
<tr>
<td>Moderate</td>
<td>9-12</td>
<td>1-6 days</td>
</tr>
<tr>
<td>Severe</td>
<td>3-8</td>
<td>7 days or more</td>
</tr>
</tbody>
</table>


**Note:**

If the GCS and PTA do not correlate, the Client will be assigned to the greater of the two severity categories.

Example: A Client has a GCS score of 14 and also experiences PTA of 2 days. Based on the more severe indicator (PTA of 2 days) the Client is considered to have a moderate TBI.

If notification of a TBI has been delayed but is less than 12 months after the injury, the Case Owner will check the GCS and PTA where provided, and any other information such as clinical notes, to review the concussion symptoms and decide if it is appropriate for the Client to access the Concussion Service. ACC may refer a Client to the Concussion Service to have the diagnosis investigated by the Medical Specialist.
11. Service Delivery

11.1. Referral

The referrer must only refer Clients who meet the eligibility criteria. The Supplier should decline any referral that does not meet the eligibility criteria.

Who can refer?

| At the DHB | Can refer a Client to the service by sending the completed ACC883 form to the nearest ACC Short Term Claims Centre for consideration. A qualified medical professional must have noted in the Client’s DHB clinical notes either a confirmed diagnosis or a direction to refer to the service. |
| In the community | Can refer a Client by sending the completed ACC883 or letter of referral with clinical notes to ACC directly or to a Concussion Service Supplier who must forward it to ACC for approval. |
| ACC | Can refer a Client to the Concussion Service if they consider that the Client may have sustained a TBI. The Case Owner also completes the ACC883 form to ensure the Supplier receives consistent information and provide any other information relevant. If there has been no diagnosis of TBI by a medical professional, the Case Owner will request a medical assessment to confirm the diagnosis. |

The referral form

The referrer should use the ACC883 Concussion Service Referral form which is located on the ACC website. DHB referrers must use the ACC883 Referral form and send it to their appropriate ACC Short Term Claims Centre. The ACC883 is an acceptable notification of a concussion diagnosis where the form is signed by a medical practitioner.

Letters of referral

Some referrers use other formats such as a letter of referral. ACC considers them to have insufficient detail, unless they are accompanied by clinical notes outlining presenting symptoms, pre-injury health status and any other potential rehabilitation impact.

ACC does not consider a letter of referral sufficient to update the diagnosis on the ACC45.

The Supplier and ACC will contact the referrer at every occasion recommending the use of the ACC883 Referral form and to send it to ACC.

Who cannot refer?

Other clinical professionals, such as a physiotherapist in the community, cannot refer a Client to the Concussion Service. They may, however, refer a Client to a registered medical practitioner for a medical assessment, after which the Client may be referred to the Concussion Service. A Client cannot self-refer.
Accept or decline

If the referral meets the criteria ACC will notify the Client directly and send the ACC883 referral form to the Supplier to start the service. If the claim does not meet the criteria and is declined ACC will notify the referrer and the Client. The Supplier will be notified if the referral came via the Supplier.

11.2. Initial purchase order

A referral to a Supplier for the Concussion Service will be accompanied by an initial purchase order (PO) that supports the timely assessment and triage of the Client. The purchase order will state the TBI21 and TBI29 codes only but includes approval of all the following assessment and triage service item codes:

Table 4 - Initial purchase order codes (note: only the TBI21 and TBI29 will be shown on the initial purchase order)

<table>
<thead>
<tr>
<th>Service Item Codes</th>
<th>Quantity/Time</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBI21 Education &amp; Assessment</td>
<td>3 hours</td>
<td>Supplier invoices for actual time.</td>
</tr>
<tr>
<td>TBI29 Key worker/coordinator</td>
<td>2 hours</td>
<td>Supplier invoices for actual time.</td>
</tr>
<tr>
<td>TBI13 Case Review by Clinical Neuropsychologist</td>
<td>1 fee only</td>
<td>Single fee</td>
</tr>
<tr>
<td>TBI14 Case Review by Medical Specialist</td>
<td>1 fee only</td>
<td>Single fee</td>
</tr>
<tr>
<td>TBI22 Allied Health Assessment</td>
<td>2 hours</td>
<td>Supplier invoices for actual time.</td>
</tr>
<tr>
<td>TBI23 Neuropsychological Screen</td>
<td>5 hours</td>
<td>Supplier invoices for actual time.</td>
</tr>
<tr>
<td>TBI30 Medical Assessment</td>
<td>2 hours</td>
<td>Single fee</td>
</tr>
</tbody>
</table>

This will enable the Supplier to immediately proceed with the Assessment and Triage Services without having to come back to the Case Owner to update the PO.

The Supplier will submit the ACC884 Client Summary once all the assessments are complete and will make recommendations on the way forward. Prior to this the Supplier will keep the Case Owner updated on the Client’s progress.

11.3. Investigation of clinical and psycho-social background of client

The service item TBI21 is designed to allow the Supplier to investigate both clinical and the psycho-social background of the Client. The following process map shows the comprehensive investigation required under TBI21. The Supplier will only complete the assessments which are clinically necessary.

11.4. Investigation and Triage

While the Supplier may operate their interdisciplinary team in their own way ACC expects that all the components of the following process map to be present.
11.5. Gathering of Clinical Notes

Where the diagnosis is uncertain and/or the TBI unconfirmed the Supplier should obtain up to five years’ of clinical history from the Client’s GP. This is to build a full medical history. This medical information is made available to the medical specialist to conduct a differential diagnosis and to other providers within the IDT only when clinical necessary.
The Supplier should notify the Client and seek their permission to obtain the clinical notes. Should the Client refuse then the Supplier should suspend further services and refer the Client to the Case Owner.

The information collected should include

- **GP clinical notes** covering all presentations including previous brain injuries and health issues (up to five years if relevant). Specifically, pre-injury health issues such as depression, mental illness etc. This information can be provided to the specialists and will help in their diagnosis.

- **DHB clinical notes** if the Client was diagnosed and treated at any DHB service

- **Work or education information** to help assess the cognitive demands that have been and could be on the Client throughout the recovery

- **Family composition and responsibilities** to help assess any stressors that may hinder recovery and also where ACC may need to provide supports

- **Social background** to identify any underlying social issues that may hinder recovery

- **Any other relevant records** (eg mental health). This is particularly necessary where a differential diagnosis is required and the Client has clinical complexity, persisting concussion symptoms and/or atypical presentation.

The Supplier is responsible for ensuring the Client’s personal information is gathered and stored in a way that meets the relevant privacy legislation. Once the service is complete the Client’s medical information should be securely destroyed. The clinical information not relating to the concussion or other brain injuries should not be made available to ACC.

The Supplier may arrange for the payment of any fees in relation to obtaining clinical notes directly with the holder of the clinical records. Alternatively, the Supplier may request the Case Owner to arrange for the collection of clinical notes.

### 11.6. Case Reviews

It is important that the Supplier collects all information about the Client that may be relevant to their rehabilitation and recovery. The review of clinical notes by the medical specialist (TBI14) and the clinical neuropsychologist (TBI13) will identify any indication that the Client does not need the clinical assessments the Client was referred for. The specialists do not need to attend an actual meeting where this would be inefficient but ACC encourages face to face IDT meetings as they are considered best practice.

If the case reviews agree with the referral, then assessments by the medical specialist (TBI30) and/or the clinical neuropsychologist (TBI23) should be arranged.

### 11.7. Diagnosis

Only a Medical Specialist or GP can make a diagnosis of concussion. This is because only a Medical Professional (GP etc) can rule out (or confirm) the presence of any other medical conditions which may be contributing to the Client’s symptoms.

A referral may be sent to a Supplier with the clinical diagnosis accepted or still in question. Where the diagnosis is accepted, the Supplier can progress immediately to investigation, assessment and therapy. If the diagnosis is still in question then the Case Owner will direct the Supplier to confirm the diagnosis using a comprehensive clinical investigation including a differential diagnosis. The investigation may also include all disciplines such as a musculoskeletal physiotherapist for neck and
shoulder injuries.

The medical assessment should take a neutral point of view until the appropriate tests and investigations have been taken to rule out other causes for the presenting signs and symptoms. Once the TBI diagnosis is confirmed, the impact of the TBI should be assessed and advice provided on appropriate therapy and prognosis.

Where the Client’s diagnosis is not confirmed, the Supplier should ensure the Client understands that the diagnosis is being investigated and that they may or may not have a TBI. This is to minimise the likelihood of the Client becoming invested in the TBI diagnosis when, in fact, it maybe another injury such as neck strain. Interim advice on managing pain and other systems can be provided as required without the diagnosis (See Providing Education).

The Supplier is responsible for ensuring they have a confirmed diagnosis before therapy services are provided.

11.8. Providing Education (TBI21)

The education given to the Client and their family/whānau should be clear and use plain language. If a diagnosis was not confirmed, the Supplier will limit the education content to dealing with the symptoms. This is to guard against client’s becoming invested in a TBI diagnosis. Once the diagnosis is confirmed as a mild or moderate TBI, then education on TBI can be provided.

Table 5 - Education (TBI21) must cover, but not be limited to, the following items:

<table>
<thead>
<tr>
<th>Item</th>
<th>Content details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms</td>
<td>• Describe the symptoms</td>
</tr>
<tr>
<td></td>
<td>• Describe the recovery journey</td>
</tr>
<tr>
<td></td>
<td>• Describe the treatments that will target the individual symptoms</td>
</tr>
<tr>
<td></td>
<td>• Cover lifestyle responses and dealing with stress</td>
</tr>
<tr>
<td>Rehabilitation process</td>
<td>• Rehabilitation response</td>
</tr>
<tr>
<td></td>
<td>• How it’s different for everyone</td>
</tr>
<tr>
<td></td>
<td>• Self-management</td>
</tr>
<tr>
<td></td>
<td>• Help from family/whānau and friends</td>
</tr>
<tr>
<td></td>
<td>• Supplier support via an interdisciplinary team</td>
</tr>
<tr>
<td></td>
<td>• Getting back to normal functioning – having realistic expectations</td>
</tr>
<tr>
<td></td>
<td>• Returning to work if appropriate</td>
</tr>
<tr>
<td>Brain injury</td>
<td>• Structure of the brain</td>
</tr>
<tr>
<td></td>
<td>• Mechanism of injury</td>
</tr>
<tr>
<td></td>
<td>• Acute response</td>
</tr>
<tr>
<td></td>
<td>• Prevention of subsequent TBIs</td>
</tr>
</tbody>
</table>
### Item | Content details
--- | ---
Other support (where appropriate) | • Other ACC services available  
• Working with the Case Owner  
• Working with the employer  
• Other support available in the community

The Supplier should explain the partnership between the Supplier and the ACC Case Owner in the Client’s rehabilitation.

The Supplier may choose to provide education on concussion and brain injury to Clients in a group session. The time will be spread across all attending Clients (as per the Provider Handbook).

#### 11.9. Triage

The Concussion Service has a strong triage focus. The full interdisciplinary team will determine the suitability of the Concussion Service for the Client using all available information.

**Table 6 – Triage activity**

<table>
<thead>
<tr>
<th>If the Client...</th>
<th>the Supplier should</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has recovered and no longer needs the CS</td>
<td>Send the ACC884 to the Case Owner as soon as identified and recommend the Client exits CS</td>
</tr>
<tr>
<td>Has needs that can be met within the resources of CS, either by itself or in conjunction with other services</td>
<td>Continue CS delivery</td>
</tr>
</tbody>
</table>
| Has needs that are greater than can be provided in the CS | Send the ACC884 to the Case Owner as soon as identified and recommend the Client exits CS  
ACC Case Owner will make appropriate referrals to other services |

#### 11.10. Assessing risk to recovery

The risk to recovery assessment matrix (See Appendix 2) describes the Client’s situation using a bio-psycho-social framework. It is designed to be a communication tool between the Supplier and ACC. It is not a clinical assessment and has no clinical validity.

The tool describes potential barriers to the Client’s recovery using risk factors within the four domains - physical, psychological, work, and social. The (0) rating describes where there is potentially little or no impact on the Client’s recovery, whereas the (4) rating signals that the risk item could pose a significant impact in the Client’s recovery.

The Supplier’s IDT keyworker/coordinator will gather current and historical information about the Client through interviewing the Client. They will review all available clinical information via the clinical notes.
If the Supplier believes that the accuracy of the risk assessment is compromised by a lack of disclosure on the Client’s part they may, with the Client’s approval, contact the Client’s family, friends, and employer and ask relevant questions.

The Supplier must take care to maintain Client confidentiality. If risks cannot be identified due to non-disclosure then the assessment will be at the less complex rating (1-2). The request for services will reflect this assessment. The Supplier should explain to the Client that the amount of services available is based on the information they give.

**Note:** While a Supplier may choose to have this risk assessment undertaken by a doctor, psychologist or neuropsychologist, the risk assessment will only be paid at the contract TBI21 allied health rate as it is not a clinical assessment.

The risk assessment is an important part of the triage process and can assist in determining whether the Client’s needs can be met within the limits of the service.

### 11.11. Assessment of Therapy Needs

The Client’s therapy and support needs should be assessed throughout the rehabilitation. All clinical assessments will be completed by professionals operating within their scope of practice and within the interdisciplinary team.

*For guidance on what to include in the Clinical Neuropsychologist assessment see Appendix 3.*

### 11.12. Planning Rehabilitation

Where the Client is progressing into therapy, the Supplier’s interdisciplinary team will develop a rehabilitation plan that describes Client’s goals expressed as SMART goals (specific, measurable, achievable, realistic and time framed) and outline the therapy required to meet those goals.

The Supplier should either provide a copy of the rehabilitation plan to ACC or summarise the plan in the ACC884 Concussion Service Client Summary. The ACC Case Owner and the Supplier will finalise and agree service composition and timeliness. The plan may be amended as additional information becomes available.

### 11.13. Use of time – Number of hours required

The Supplier will outline a treatment plan on the ACC884. The plan will be based on current best practice and will recommend the types of services and number of hours required up to a maximum of 8 hours. The Supplier can determine how that time is to be used.
### 11.14. Service Timeframes

Table 57 - Timeframes and responsibilities for delivering the service

<table>
<thead>
<tr>
<th>Service Activity</th>
<th>Responsibility</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Duration</td>
<td>Supplier</td>
<td>Six months from date of acceptance of referral or as agreed with ACC.</td>
</tr>
<tr>
<td>Notification of an acceptance of Concussion Service Referral form</td>
<td>Supplier will notify ACC</td>
<td>Within one business day from referral receipt by Supplier.</td>
</tr>
<tr>
<td>Commencement of Services to Client</td>
<td>Supplier</td>
<td>Within 5 business days of acceptance of referral</td>
</tr>
<tr>
<td>Submission of Client Summary form – client does not require further services</td>
<td>Supplier will submit to ACC</td>
<td>Within five business days of completion of the agreed services and/or Service Exit.</td>
</tr>
<tr>
<td>Submission of Client Summary form – client requires further services</td>
<td>Supplier will submit to ACC</td>
<td>Within two business days of the need for further services being identified.</td>
</tr>
<tr>
<td>Education and Risk Assessment and Case Review by a Neuropsychologist and Medical Specialist</td>
<td>Supplier</td>
<td>Within 10 business days of the acceptance of the referral</td>
</tr>
<tr>
<td>On receipt of a Client Summary form requesting further services.</td>
<td>ACC will notify the Supplier</td>
<td>Within two business days of receipt of the Client Summary requesting further services.</td>
</tr>
<tr>
<td>Request for Clinical Notes</td>
<td>Supplier will provide to ACC</td>
<td>Within five business days of the request being received.</td>
</tr>
<tr>
<td>Where the Client does not attend and does not notify the Provider.</td>
<td>Supplier will provide a Did Not Attend Report form.</td>
<td>As soon as possible, but within three business days of the missed appointment.</td>
</tr>
<tr>
<td>Receiving the Did Not Attend Report form from the Supplier.</td>
<td>ACC will review the form and make a decision on whether to fund the DNA</td>
<td>Within two business days of receipt of the form.</td>
</tr>
</tbody>
</table>

### 11.15. Therapy

The Client’s rehabilitation needs and achievements will be continually assessed to ensure the service is tailored to the Client. Therapy services will be provided in order to achieve specific outcomes and no unnecessary therapy will be provided. If a Client needs more services than those available in the Concussion Service, the Supplier will notify ACC immediately to request approval.

### 11.16. Key worker/coordinator

The key worker/coordinator is a significant contributor to the success of the service and is important to the achievement of Client goals. The Supplier will nominate a rehabilitation professional to be the
key worker/coordinator for each Client. This role includes:

- Holding, on behalf of the Supplier and the interdisciplinary team, overall responsibility for the Client’s outcomes
- Coordinating providers within the service to ensure the greatest efficacy and efficiency of the Client’s goals and outcomes
- Ensuring the clinical notes are kept up to date and are of a high standard
- Informing ACC if there are any issues with providing the service
- Ensuring reports are provided on time and accurately reflect the service provided
- Maintaining links with community groups and other organisations working with the Client
- Coordinating and liaising with ACC and non-ACC services to ensure the Client receives smooth, supported transitions and integrated services
- Maintaining an ongoing relationship with the Client’s ACC Case Owner to ensure high quality service and outcomes are achieved.

The key worker/coordinator is most effective in their relationship with the Client when they:

- Maintain a supportive, open relationship
- Are committed to working within the bio-psycho-social model
- Approach the relationship in a holistic, Client and family-centred way
- Are proactive in their contact with the Client, family and whānau
- Work with families’ strengths and ways of coping.
- Are responsive to the Client’s cultural needs
- Work across agencies

11.17. Interdisciplinary Teams

The Supplier must have an interdisciplinary team (IDT) fully qualified in their profession with a minimum of two (full time) years’ experience in acquired or traumatic brain injury who meet the criteria listed in the Service Schedule. The IDT is coordinated by the key worker/coordinator throughout the service to ensure that members of the IDT are engaged as appropriate and participate in the rehabilitation planning.

The IDT will meet on a regular and scheduled basis to discuss the Client’s assessment and treatment rehabilitation needs. Notes of the IDT meeting/s will be taken by the key worker/coordinator who will summarise the individual clinical opinions. Notes from the IDT meetings will be kept in the Client’s clinical notes and will be available to ACC if requested.

The Supplier’s interdisciplinary team must include:

- Medical specialist
- Clinical neuropsychologist
- Occupational therapist
• Physiotherapist

The Supplier’s interdisciplinary team may also include:

• Registered nurses, preferably with a rehabilitation speciality
• General practitioners
• Speech language therapists
• Social workers
• Optometrists

Note: All children should be assessed by a Paediatrician. Children should always be referred to Training for Independence after they have been clinically assessed as having a TBI.

11.18. Specialist paediatric rehabilitation

Where the Supplier intends to provide specialist paediatric rehabilitation (16 years and under) all service Suppliers must have at least two years’ experience providing brain injury therapy services to this age group. On application, or any time thereafter, the Supplier should notify ACC of their ability to provide paediatric services to ensure ACC can refer appropriately.

11.19. Notifying ACC of client progress

The Supplier will keep in contact with the Case Owner throughout the rehabilitation programme via email and telephone contact. Detailed clinical reporting is not purchased separately in this service.

The only reporting which is required to be sent to the Case Owner includes:

• ACC884 Client Summary Form - sent to the Case Owner when the:
  - Rehabilitation plan has been agreed by the interdisciplinary team; and
  - Rehabilitation is complete; and/or client is being discharged

• Neuropsychological assessment screen - TBI23 (if conducted). A brief summary of this screen including recommendations must be shared with the IDT and ACC. The requirement to provide a useful summary report which includes recommendations must be balanced against the Client’s capacity to undertake testing at this early post-injury stage when fatigue and headaches are presenting symptoms.

  Lengthy testing is not required. Clinical judgement must be applied.

  See the appendix 3 for information about what is required in the neuropsychological assessment.

• Clinical notes if requested by the Case Owner

11.20. Clinical notes and records kept by the interdisciplinary team

Client clinical notes written and held by Providers should meet or exceed the expectations of the professional bodies to which each Provider holds membership. That is, at a minimum, the clinical notes should be detailed, legible and contain all the information relevant to the Client’s injury and rehabilitation e.g. the Client’s status, rehabilitation needs, and all treatments provided to date.

11.21. ACC may request clinical notes

The Supplier must send ACC the Client’s clinical notes in the following situations:
• The summary information provided in the ACC884 is insufficient
• The Client did not achieve the expected rehabilitation outcome. The Supplier must provide ACC with a copy of their full clinical notes with the ACC884. ACC will then use this information to support the on-going planning of the Client’s rehabilitation.
• When requested by ACC

Suppliers will provide any clinical notes within 5 business days when requested.

11.22. If a detailed report is requested by ACC

If a more detailed report is requested by ACC, the Supplier may charge ACC for time spent preparing the writing this report using the MEDR code. This cost is outside of the Concussion Contract and should be discussed with the Case Owner.

11.23. Referrals to Other Specialists for Assessment (TBI25)

The Supplier may refer the Client to clinical specialists outside of the interdisciplinary team, on approval from the Case Owner, to obtain further advice on the Client’s specific rehabilitation needs. This will be funded on a cost recovery basis using the TBI25 code within the maximum funding limit of the Concussion Service.

11.24. Links with Community Service Providers

 Suppliers are encouraged to maintain links within the community and, where a need is identified, Clients may be referred to appropriate community service providers, eg:

• Alcohol and drug addiction counsellors
• Vocational counsellors
• Anger management services
• Driving assessment services
• Cultural advisors, or services for Māori and Pacific Islanders and other ethnic groups if appropriate, which may include interpreting services
• Consumer advocacy and support services

The costs for these services would usually be met outside of the Concussion Contract.

12. Service Administration

12.1. Service location

Face to face meetings with Clients should be held. While text and email are good communication tools for exchange of information, they lack the immediate feedback required for engaging the Client in their rehabilitation.

Clinic setting

Concussion Services should usually be provided in a clinic setting. This is because a clinic setting removes sources of distraction which may impair the Client’s ability to engage in services. The same clinic should be used, whenever possible, rather than separate provider locations. This enables different professions in the IDT to get to know one another and work collaboratively as per the requirement for services to be delivered as an interdisciplinary team.
Neuropsychological testing should **always** be undertaken in a clinic environment.

**Services may be provided in a community setting**

Where it is agreed between the Client and the Provider, that the Client’s needs are best met by services being provided in the community, appropriate community locations may include: the Client’s home, workplace or other community setting.

Examples of situations where it may be appropriate to provide services in a community setting:

- The Client’s injury - for example: where travel to a clinic would put the Client at risk or adversely affect their rehabilitation outcome
- Availability of IDT professionals
- Remote regions where districts are geographically dispersed
- At the Client’s request

Rooms used should be in a quiet location so that the Client is not distracted when engaging in counselling, therapy and rehabilitation. The delivery of services in the Client’s home is covered under the professional codes of practice and is not described in this document.

The Suppliers travel to and from the clinic and the running costs of the clinic is considered to be a business overhead and will not be separately funded by ACC.

**Remote or Distance Rehabilitation - TeleRehab**

In exceptional circumstances, interventions may be delivered remotely via a technological means such as phone or video conferencing or via Telehealth.

Suppliers can choose to provide services to Clients using tele-rehabilitation as part of their rehabilitation programme. Suppliers must comply with the Telehealth guidelines.

The NZ TeleHealth Resource Centre ([https://www.telehealth.org.nz/regulations-and-policies](https://www.telehealth.org.nz/regulations-and-policies)) has a variety of resources available to practitioners and is able to assist Suppliers to develop their tele-rehabilitation capability. ACC cannot and will not instruct a provider to deliver services remotely for any reason. Should the Supplier choose to provide services remotely the Supplier remains fully responsible for their actions, any consequences and the Client’s rehabilitation outcome.

**12.2. Maximum duration for delivery of service**

The maximum duration for delivery of this Concussion Service is six months (from the date of the referral to the last treatment date). It is expected that Suppliers will work to ensure the Client achieves the service objectives within 16 weeks. Clients with more complex and longer term service needs should have been triaged from the service.

Suppliers should be available for the Client as needed over the six month period. The Supplier should not retain therapy hours to provide a follow-up service as therapy hours are for face-to-face therapy. Client follow-up via phone is considered part of the overhead component of the fees paid.

ACC will monitor Client duration based on the length of time between the first date of service to the last date of services invoiced. Service duration will be discussed regularly as part of the dialogue between Supplier and Case Owner.

**12.3. Timeframes**

The Service adapts to the needs of the Client so there may be situations where the timeframes
outlined in the service specification are not appropriate. The Supplier is responsible for ensuring that timeframes are discussed and agreed with the Case Owner.

Section 8 of the ACC884 should record a brief description of the Client, their recovery needs and rehabilitation plan. Alternatively a separate rehabilitation plan can be included. The plan should outline expected timeframes for reviews and outcomes such as return to work etc.

Table 8 – Completing ACC884 setting out services and hours required

<table>
<thead>
<tr>
<th>Service Item</th>
<th>Hours</th>
<th>Variations</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBI21 – Education &amp; Assessment</td>
<td>3</td>
<td>Hours for all service items maybe varied in agreement with the Case Owner but should not exceed the caps and must meet the following requirements:</td>
</tr>
<tr>
<td>TBI22 – Allied Health Assessment</td>
<td>2</td>
<td>• Multi-disciplinary services are required (single discipline needs are met under other contracts)</td>
</tr>
<tr>
<td>TBI23 – Neuropsychological Screen</td>
<td>5</td>
<td>• Rehabilitation plan fully explains the need for services, goals and expected outcomes and timeframes</td>
</tr>
<tr>
<td>TBI13 – Neuropsychological Case Review</td>
<td>Fee</td>
<td>• Services do not exceed the maximum funding of $3,200 for the total service cost</td>
</tr>
<tr>
<td>TBI30 – Medical Assessment</td>
<td>Fee</td>
<td></td>
</tr>
<tr>
<td>TBI14 – Medical Specialist Case Review</td>
<td>Fee</td>
<td></td>
</tr>
<tr>
<td>TBI25 – Other Specialists</td>
<td>At cost</td>
<td></td>
</tr>
<tr>
<td>TBI26 – Allied Health or Nursing therapy</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>TBI27 – Psychological Consultation</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>TBI28 – Medical Consultation</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>TBI29 – Key worker/coordinator</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>

12.4. Service time

The scheduled service time will be appropriate to clinical need and best practice and will only be as long as required. If the time with the Client is less than required the Supplier should fill in the time up to the scheduled time with Client-related activities such as updating Client notes, phone calls etc.

12.5. Maximum funding limit

The Service has a maximum funding limit of $3,200, excluding Goods and Services Tax, travel costs and the single payment for non-attendance by the Client (Did-Not-Attend fee). ACC will approve services which are appropriate to the Client’s diagnosis, clinical and risk assessments completed by the Supplier up to that limit.

For treatment within the Concussion Service to be approved services must be:

- Requested on the ACC884 Concussion Service Client Summary form
- Provided within the maximum funding limit of $3,200.

The Supplier is responsible for ensuring that the maximum funding limit is not exceeded. Should the Supplier exceed the maximum funding limit, ACC may choose to recover the overpayment.
12.6. Purchase orders

The Supplier must hold a purchase order that approves the specific service items. The initial purchase order will approve all services available in the Triage and Assessment Services (see table 4). The Supplier will only invoice for the hours used.

The Supplier may provide the services up to the approved maximum spend in the best way determined by the interdisciplinary team and based on the identified clinical need.

If a diagnosis of TBI is confirmed, and therapy is required, the Supplier will send an ACC884 form requesting further services. The Case Owner will send an amended Purchase Order approving additional services.

The Supplier is not able to trade one service item for another. If the Client’s service needs have changed, the Supplier should contact ACC with an amended ACC884 Concussion Service Client Summary form and negotiate an amendment of the purchase order.

ACC is not liable to pay for services provided which were not specified on the purchase order.

12.7. Completing or extending the service

After the investigation and planning the ACC884 Concussion Service Client Summary form must be sent to ACC

- Within two business days - when further treatment service needs are requested.
  
  The two day requirement recognises that both the Supplier and ACC want to respond promptly to ensure the Client’s access to rehabilitation is not restricted. If this response time is not required the Supplier can indicate a more appropriate timeframe on the form or in discussion with the Case Owner.

- Within five business days - when all services are complete, no further services are required and the Client is exiting the Concussion Service.
  
  The five day requirement recognises that the Client is no longer in need of services and therefore, while a timely response is required, there is no urgency.

The Supplier can request further services at any time by submitting an updated ACC884 to the ACC Case Owner. If further services are requested the ACC Case Owner will review the case, make a determination and, if approved, forward the purchase order within two business days. If the continuance is not approved, the Case Owner will send decline letters to the Client and the Supplier.

12.8. Other ACC services

The Supplier may recommend that the Client receive other ACC services both during and after this service when they believe it will improve the Client’s recovery.

- During – Vocational Rehabilitation Services, Home and Community Support Services
- After – Neuropsychology Service, Psychology Services, Clinical Services, Training for Independence Services (TI), Pain Management Service.

The Case Owner is responsible for reviewing the recommendations and deciding if the Client is entitled to the services recommended. Where a recommendation has been made for a client to exit the Concussion Service and be referred to a TI service, the Supplier should make every effort to ensure this is a smooth transition by: notifying the Case Owner as early as possible and provide support to the Client until the TI service is underway by keeping in touch with the Case Owner and
keeping the Client informed of timeframes.

Where there are delays which are impacting on the Client’s recovery, please raise the issue with ACC using the escalation process.

Where a recommendation has been made for the client to undertake Vocational Rehabilitation, the Concussion Service Supplier should take the lead in determining when the Client is clinically ready to participate in Vocational Rehabilitation.

If the Client requires Clinical Psychology Services to monitor psychological progress, a referral under Psychology Services should be made rather than a referral to a TI programme. This is because a referral under the Clinical Psychology contract will ensure adequate reporting of presenting symptoms, relationship to injury, background history of any mental health/substance abuse, treatment plan and response to therapy.

12.9. **Client non-attendance**

Clients who keep their appointments generally take less time to recover and achieve better recovery outcomes than those who do not. ACC will pay one non-attendance (DNA) fee per Client, no matter how many times they failed to attend an appointment. The service item code for non-attendance is TBIDNA.

The Service purchase order is updated for a single DNA fee by the Case Owner when the Supplier:

- Sends the Case Owner an ACC885 Concussion Service - Did Not Attend report within one business day of the missed appointment and explains why the Client did not attend, and
- Has made all reasonable efforts to remind the Client of the appointment, such as an appointment card, a reminder letter, a phone call the day before and finally a text message on the day to the Client’s and a contact person’s mobile phone.

If the above criteria are met, ACC will confirm funding within two business days of receiving the form.

12.10. **Invoicing the Client for non-attendance**

ACC plays no part in scheduling appointments. Therefore after the first incidence of non-attendance where ACC has already paid a non-attendance fee, the Supplier may choose to invoice the Client directly where the Client continues to not attend appointments.

The Supplier should alert the Client and their supporting family and whānau both verbally and in writing at the start of the service about the possibility of being charged for non-attendance. ACC expects that the Supplier will:

- Not charge more than the agreed ACC fee that would have been payable
- Take into consideration the Client’s financial situation.

12.11. **Service exit due to non-attendance**

The Supplier must notify ACC on each occasion of non-attendance. If the DNA fee is not being paid, notification can be by phone or email. If Clients repeatedly do not attend appointments they can be exited from the service. This may result in the Case Owner reviewing all services and entitlements the Client is in receipt of, including weekly compensation payments.
12.12. Client exit

- A Client exits the service when they have achieved the identified outcomes that enable them to return to work or school, and/or normal daily living.

- The Client is considered to be discharged six weeks after the last date of service provision.

Note:
If the Client has not achieved these outcomes within the specified timeframe the Supplier must make a full comment on the ACC884 Concussion Service Client Summary form and record whether this is for non-compliance or a non-injury related factor, e.g. mental health issues. Where mental health issues are identified, Clients should be referred to the DHB. In cases where a Client already has a mental health case worker, or is being managed via their GP, the Supplier should work closely with the mental health provider.

12.13. Post-service Client support

Ongoing support will be provided to the Client throughout the rehabilitation programme and the Supplier will act as a point of contact for the six months from the date the referral was received. The Supplier will contact ACC and refer the Client to their ACC Case Owner if the Client reports new symptoms.

12.14. Exclusions

The following services are not included in the Service:

- Inpatient services for TBI
- Elective surgical treatment arising out of any initial assessment
- Social rehabilitation assessments
- Vocational rehabilitation services
- Radiological and other clinical investigations, for example:
  - computerised tomography (CT)
  - magnetic resonance imaging (MRI)
  - electro-encephalogram (EEG)
- Sleep studies.

13. Invoicing ACC

13.1. Reimbursement of costs when requesting a copy of Client Clinical Notes

Scanned and emailed documents are preferred for privacy reasons. If mailed, ACC will reimburse the Supplier at ACC’s standard photocopying rates.

Where a Supplier has obtained up to five years’ of GP Client notes and is invoiced by the GP they can be reimbursed by invoicing ACC using the service item code COPY up to a $30 @ $1 per page.

Where the Supplier is a DHB and reviews up to five years’ of DHB notes they cannot bill ACC as they have not incurred a cost, unless a copy of those notes is requested by ACC as which point ACC will pay the normal changes.
Where the Supplier is not a DHB and they obtain up to 5 years of DHB notes and are billed by the DHB they can be reimbursed by ACC billing COPY up to a $30 @ $1 per page

Where a Supplier obtains Client notes but is not billed then the Supplier cannot be reimbursed.

<table>
<thead>
<tr>
<th>Supplier</th>
<th>Service code</th>
<th>Service description</th>
<th>Fee (GST excl)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHB</td>
<td>DHBC</td>
<td>Photocopying of medical notes. Paid per page and includes all administration time to process the request</td>
<td>DHB providers refer to the existing price schedule.</td>
</tr>
<tr>
<td>Non-DHB</td>
<td>COPY</td>
<td>Used when requesting photocopies of notes that do not need reviewing and editing by a GP or specified treatment provider Includes admin tasks, such as searching, reviewing and collating</td>
<td>$1.00 per page (min $5.00, max $30.00) • Minimum charge of 5 pages • Maximum of 30 pages</td>
</tr>
</tbody>
</table>

### 13.2. Invoicing for services

The invoice should present the time in hours and minutes. Each separate service should be listed by service date. See example below:

<table>
<thead>
<tr>
<th>Information</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client name</td>
<td>John Smith</td>
</tr>
<tr>
<td>Client number</td>
<td>123456789</td>
</tr>
<tr>
<td>Purchase order number</td>
<td>1234567</td>
</tr>
<tr>
<td>Service date</td>
<td>DD/MM/YY</td>
</tr>
<tr>
<td>Service code</td>
<td>TBI21</td>
</tr>
<tr>
<td>Time/ Quantity</td>
<td>1 hour 15 mins</td>
</tr>
<tr>
<td>Amount claimed</td>
<td>$141.27 (GST Exc)</td>
</tr>
<tr>
<td>Service date</td>
<td>DD/MM/YY</td>
</tr>
<tr>
<td>Service code</td>
<td>TBI22</td>
</tr>
<tr>
<td>Time/ Quantity</td>
<td>30 mins</td>
</tr>
<tr>
<td>Amount claimed</td>
<td>$56.51 (GST Exc)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Minutes</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>8.3</td>
</tr>
<tr>
<td>10</td>
<td>16.7</td>
</tr>
<tr>
<td>15</td>
<td>25.0</td>
</tr>
<tr>
<td>20</td>
<td>33.3</td>
</tr>
<tr>
<td>25</td>
<td>41.7</td>
</tr>
<tr>
<td>30</td>
<td>50.0</td>
</tr>
<tr>
<td>35</td>
<td>58.3</td>
</tr>
<tr>
<td>40</td>
<td>66.7</td>
</tr>
<tr>
<td>45</td>
<td>75.0</td>
</tr>
<tr>
<td>50</td>
<td>83.3</td>
</tr>
<tr>
<td>55</td>
<td>91.7</td>
</tr>
<tr>
<td>60</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Divide the hourly rate with the appropriate percentage to calculate the portion of the hourly rate.

1 hour $13.02
15 mins = 25% $28.25
Total $141.27
13.3. Travel costs

ACC will reimburse travel costs where a Supplier travels within a district to provide services to clients. Districts, also known as Territorial Authorities (TAs), are used to define areas of coverage. When a Supplier has applied for and been approved for a specific district, they are agreeing that they can deliver within that district (or individual TA area). Travel to and from that district is at their own cost unless otherwise agreed with ACC.

ACC does not pay the following transport costs:

- Transporting the Client to and from the clinic
- Transport from the Supplier’s place of residence to the base of operation
- Transport from the base of operation to another base of operation

**Invoicing Travel distance (TBITD10)**

If the services are provided in a place other than the Supplier’s facility and the Supplier needs to travel to the Client, travel should be managed to maximise coverage and service time and minimise the distance travelled.

Appointments will be arranged to ensure the shortest distance between Clients, thereby minimising the time and distance travelled. The Supplier cannot claim travel time or distance when a Supplier travels from one base of operation to another or from their private residence to the base of operation.

ACC expects that Suppliers and their staff work to minimise travel costs. Travel from a base of operation should be for services to a number of Clients. *These diagrams are best viewed online.*
As represented in this loop ✅ rather than this star ✗

In the case of the loop the Supplier would recognise a single incidence of 20km, whereas the star would recognise four incidences of 20km.

In many instances Clients may not all be ACC Clients. Allocation of travel costs between the ACC and non-ACC Clients should be done in a fair and reasonable way that is reflective of the true costs to the service purchasers/funders. This example assumes one of the Clients is not being funded by ACC.

<table>
<thead>
<tr>
<th>✓</th>
<th>Total Travel (km)</th>
<th>Return Travel (km)</th>
<th>Tot. Incl Return Travel (km)</th>
<th>ACC Clients (km)</th>
<th>Less 20 km deduction</th>
<th>Invoiced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client 1 – Other</td>
<td>20</td>
<td>7</td>
<td>27</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client 2 – ACC</td>
<td>18</td>
<td>7</td>
<td>25</td>
<td>25</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Client 3 – ACC</td>
<td>25</td>
<td>7</td>
<td>32</td>
<td>32</td>
<td>7</td>
<td>25</td>
</tr>
<tr>
<td>Client 4 – ACC</td>
<td>15</td>
<td>7</td>
<td>22</td>
<td>22</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Return Travel</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total km</td>
<td>106</td>
<td>28</td>
<td>106</td>
<td>79</td>
<td>20</td>
<td>59</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>✗</th>
<th>Total Travel (km)</th>
<th>Return Travel (km)</th>
<th>Total Travel</th>
<th>ACC Clients (km)</th>
<th>Less 20 km deduction</th>
<th>Invoiced to ACC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client 1 – Other</td>
<td>20</td>
<td>20</td>
<td>40</td>
<td></td>
<td></td>
<td>32</td>
</tr>
<tr>
<td>Client 2 – ACC</td>
<td>26</td>
<td>26</td>
<td>52</td>
<td>52</td>
<td>20</td>
<td>32</td>
</tr>
<tr>
<td>Client 3 – ACC</td>
<td>25</td>
<td>25</td>
<td>50</td>
<td>50</td>
<td>20</td>
<td>30</td>
</tr>
<tr>
<td>Client 4 – ACC</td>
<td>18</td>
<td>18</td>
<td>36</td>
<td>36</td>
<td>20</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>89</td>
<td>89</td>
<td>178</td>
<td>138</td>
<td>60</td>
<td>78</td>
</tr>
</tbody>
</table>

**Invoicing Travel time (TBITT5, TBITT1)**

If it takes 15 minutes to travel the first 20km and the overall time spent travelling for the day is 140 minutes, then the Supplier can invoice for 125 minutes of travel time if all the travel time relates to ACC Clients.

To maximise the use of the Supplier’s time, all attempts should be made to book the maximum number of clients throughout the day of travel, and thereby minimise the amount of time spent travelling to clients.
14. Quality Services

14.1. Qualifications, Experience and Supervision Requirements for Service Providers

All members of the IDT must meet the qualifications, experience and supervision requirements as set out below. The Supplier will notify ACC immediately regarding any changes in their ability to provide services.

Table 9 – Qualifications et criteria of the members of the Interdisciplinary Team:

<table>
<thead>
<tr>
<th>Medical Specialist</th>
<th>Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current vocational registration in, and practising within, any of the following recognised branches of medicine:</td>
</tr>
<tr>
<td></td>
<td>• Internal Medicine</td>
</tr>
<tr>
<td></td>
<td>• Neurology</td>
</tr>
<tr>
<td></td>
<td>• Neurosurgery</td>
</tr>
<tr>
<td></td>
<td>• Occupational Medicine</td>
</tr>
<tr>
<td></td>
<td>• Paediatrics</td>
</tr>
<tr>
<td></td>
<td>• Psychological Medicine or Psychiatry</td>
</tr>
<tr>
<td></td>
<td>• Rehabilitation Medicine</td>
</tr>
<tr>
<td>Experience</td>
<td>• A minimum of two years’ experience in acquired or traumatic brain injury; or</td>
</tr>
<tr>
<td></td>
<td>• Training in brain injury along with supervision until the provider has gained two years’ experience</td>
</tr>
<tr>
<td>Supervision</td>
<td>The Supervisor must be a suitably qualified health professional with a minimum of five years’ experience in acquired or TBI.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General Practitioner</th>
<th>Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The relevant experience may include but is not limited to:</td>
</tr>
<tr>
<td></td>
<td>• A fellowship in NZ GP College or an equivalent</td>
</tr>
<tr>
<td></td>
<td>• Post Graduate Diploma in Rehabilitation (preferably including Neurological Rehabilitation paper)</td>
</tr>
<tr>
<td></td>
<td>• Diploma in Occupational Medicine</td>
</tr>
<tr>
<td>Experience</td>
<td>• TBI30 - Assessments</td>
</tr>
<tr>
<td></td>
<td>A vocational interest in brain injury and with a minimum of five years’ experience in the treatment of traumatic or acquired brain injury.</td>
</tr>
<tr>
<td></td>
<td>• TBI28 - Consultation</td>
</tr>
<tr>
<td></td>
<td>A vocational interest in brain injury and with a minimum of two years’ experience in the treatment of traumatic or acquired brain injury.</td>
</tr>
</tbody>
</table>
Neuropsychologist

The Neuropsychologist must meet the following minimum requirements:

**Qualifications**
- Current practicing certificate – evidence of clinical scope of practice
- Professional association membership of at least one of the following:
  - NZ Psychological Society,
  - NZ College of Clinical Psychologists, or
  - an international neuropsychological professional body acceptable to ACC
- Have successfully completed a university based graduate or postgraduate course or papers in Clinical Neuropsychology (transcript required)

**Neuropsychology Experience**
- Demonstrate a minimum of 24 months’ full time equivalent post-graduate experience in supervised neuropsychological assessments and rehabilitation – providing evidence of where and how this experience was obtained
- Can demonstrate knowledge of, and competency to use and interpret neuropsychological tests to assess executive, attention, rate of information processing, memory, language and visuospatial functioning (provision of two anonymised neuropsychology reports required)
- Outline of areas of specialisation such as children and adolescents, working with specific cultures etc.

**Brain Injury Experience**
- Evidence of a minimum of two years’ experience in acquired or traumatic brain injury; or
- Training in brain injury, along with additional supervision, until the provider has gained two years’ experience.

**Supervision requirements for Neuropsychologist**
- Have arrangements in place for ongoing supervision with an appropriately qualified and experienced Supervisor (*see section below).

---

Requirements for status as Provisional Neuropsychologist

Where a Clinical Psychologist has completed the training requirements to practice neuropsychology but does not yet have sufficient experience (24 months post-graduate full time equivalent experience), the person can provide Services as a Provisional Neuropsychologist until the required amount of experience has been gained if they satisfy the following:

**Qualifications**
- Annual Practicing Certificate – Clinical Scope of Practice
- Professional association membership of at least one of the following:
  - NZ Psychological Society
  - NZ College of Clinical Psychologists, or
  - An international neuropsychological professional body acceptable to ACC
- Have successfully completed a university based graduate or postgraduate course or papers in Clinical Neuropsychology (transcript required).

**Supervision requirements for Provisional Neuropsychologist**
- Have arrangements in place for on-going supervision with an appropriately qualified and experienced Supervisor (*see section below).

**Additional Supervision requirements for Provisional Neuropsychologist**
When the supervisee is applying for provisional status, the Supervisor also needs to agree to the following conditions in the letter of support:
• Confirmation that they will directly observe one in five assessments undertaken to ensure correct and competent test administration skills
• Discussion of all cases with their supervisee prior to each assessment irrespective of whether the supervisor observes the assessment
• Engagement in at least fortnightly one on one supervision with the supervisee
• All assessment reports will be read and co-signed by the Supervisor
• Acknowledgement that a final supervision report from the Supervisor will be required by ACC once the supervisee has met the criteria.
• In addition to the Supervisor’s report, the supervisee should provide two anonymised neuropsychology screening reports to demonstrate knowledge of, and competency to use and interpret neuropsychological tests to assess executive, attention, rate of information processing, memory, language and visuospatial functioning.

### Clinical Psychologist or Psychologist

#### Qualifications
• A current Annual Practicing Certificate with the NZ Psychologists Board
• Professional association membership of at least one of the following:
  - NZ Psychological Society
  - NZ College of Clinical Psychologists, or
  - An International neuropsychological/psychological professional body acceptable to ACC
• Non Clinical Psychologists must provide an academic transcript.

#### Experience
• Demonstrate a minimum of 24 months’ full time equivalent post-graduate experience in supervised psychological assessment and intervention – providing evidence of where and how this experience was obtained
• Outline of areas of specialisation such as children and adolescents, working with specific cultures etc.

#### Brain Injury Experience
• Evidence of a minimum of two years’ experience in acquired or traumatic brain injury; or
• Training in brain injury, along with additional supervision, until the provider has gained two years’ experience.

#### Supervision requirements for Clinical Psychologist or Psychologist
• Evidence of agreement in place for on-going supervision with an appropriately qualified and experienced Supervisor (*see section below).

### Provisional Service Provider Requirements for Clinical Psychologist or Psychologist

Where a Clinical Psychologist/Psychologist does not have the required 24-months post-graduate clinical experience specified above, an application may be made for the person to be approved as a Provisional service provider if they meet the following criteria:

#### Qualifications
• A current Annual Practicing Certificate with the NZ Psychologists Board
• Professional association membership of at least one of the following:
  - NZ Psychological Society
  - NZ College of Clinical Psychologists, or
  - An International neuropsychological/psychological professional body acceptable to ACC
• Non Clinical Psychologists must provide an academic transcript. Evidence of at
least a level 8 qualification in a professional psychology training programme.

**Supervision Requirements for Provisional Psychologist**

Evidence of agreement in place for on-going supervision with an appropriately qualified and experienced Supervisor (*see section below)

Additional Supervision Requirements for Provisional Clinical Psychologist and Psychologist

The Supervisor needs to confirm and agree to the following conditions in the letter of support:

- Confirmation supervisor has experience assessing and treating Clients with psychological problems following physical injury and traumatic incidents, including experience in ACC mental injury assessments
- Discussion of all cases with the Supervisor on a regular basis
- Engagement in at least fortnightly one-on-one supervision with the Supervisor
- All reports read and co-signed by Supervisor during the provisional period
- A final supervision report from the Supervisor will be required by ACC, within 24 months of provisional status being granted, once the 24-month experience criteria have been met detailing whether or not the Supervisor considers that the supervisee has developed the required clinical skills to work independently on this contract.

*Supervisor Qualifications and Experience for Neuropsychologists, Clinical Psychologists and Psychologists (including applications for provisional status)*

<table>
<thead>
<tr>
<th>The Supervisor needs to provide:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor’s name and supervisee’s name</td>
</tr>
<tr>
<td>Supervisor’s qualifications - must be a Registered Psychologist with a Clinical Scope of Practice and hold a current APC with New Zealand Psychologists Board – a copy needs to be provided</td>
</tr>
<tr>
<td>Evidence of Supervisor’s current membership of New Zealand Psychological Society, or New Zealand College of Clinical Psychologists (NZCCP), or an international neuropsychological/psychological professional body acceptable to ACC</td>
</tr>
<tr>
<td>Supervisor’s length of experience - minimum of 48 months’ full time or full time equivalent post qualification experience in supervised clinical practice which includes an equivalent of at least 24 months conducting neuropsychological assessments and rehabilitation (requirement for neuropsychologists and provisional neuropsychologists only)</td>
</tr>
<tr>
<td>Evidence of Supervisor’s experience including a minimum of two years’ experience in acquired or traumatic brain injury</td>
</tr>
<tr>
<td>Frequency of supervision which will be delivered to the supervisee.</td>
</tr>
</tbody>
</table>

**Allied Health**

<table>
<thead>
<tr>
<th>Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current registration with their relevant professional body and current Annual Practicing Certificate.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum of two years’ experience in acquired or traumatic brain injury; or</td>
</tr>
<tr>
<td>Training in brain injury along with supervision until the provider has gained two years’ experience</td>
</tr>
</tbody>
</table>

**Supervision**

The Supervisor must be a suitably qualified health professional with a minimum of five years’ experience in acquired or traumatic brain injury.
### Specialists with other Scopes of Practice

<table>
<thead>
<tr>
<th>Qualifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Current registration with relevant professional body</td>
</tr>
<tr>
<td>• Annual Practicing Certificate where appropriate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A minimum of two years’ experience in acquired or traumatic brain injury; or</td>
</tr>
<tr>
<td>• Training in brain injury along with supervision until the provider has</td>
</tr>
<tr>
<td>gained two years’ experience</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Worker/Co-ordinator</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Key Worker/Co-ordinator role can be fulfilled by any professional who has</td>
</tr>
<tr>
<td>a minimum of two years’ experience in a health environment providing similar</td>
</tr>
<tr>
<td>support services.</td>
</tr>
</tbody>
</table>

### 14.2. Approval of Service Providers

Suppliers are responsible for ensuring that all members of the Interdisciplinary team meet ACC’s qualifications, experience and supervision criteria.

Suppliers will maintain records showing that all the qualifications, experience, supervision and training for all members of the interdisciplinary team. From time to time, ACC may request verification that a service provider meets the required criteria.

### 14.3. ACC Approval required for the following Service Providers:

The following service Providers must also be individually approved by ACC:

- Medical Specialists, including interns
- GPs, including Medical Registrars (completing TBI30 assessments and TBI28 consultations)
- Neuropsychologists, including provisional Neuropsychologists and interns
- Psychologists, including provisional Psychologists and interns

The Supplier is required to send ACC the following documentation for these Professionals, showing that they meet all the requirements:

- Current Annual Practicing Certificate
- Membership of relevant body
- Curriculum vitae (or other evidence) which shows experience
- Supervision arrangements (Neuropsychologists, Psychologists, including provisional)
- Evidence that Medical Registrar is working under the direct supervision of a Medical Specialist (Medical Registrars)

The documentation should be sent to: Health.procurement@acc.co.nz

ACC will review the documentation and will advise the Supplier within seven days via email, whether the applicant meets the criteria to provide services under the Concussion Service.

### 14.4. Qualified Trainees

Where the trainee is qualified in their chosen profession but does not have the required brain injury experience to operate independently they can gain that experience by:
• Participating in learning opportunities provided by the experienced Supplier that includes
  - an introduction to the operation of the Service
  - case studies of Clients with mild and moderate TBI
  - key readings about the impact, rehabilitation and recovery of traumatic brain injury

• Undertaking extra study about traumatic brain injury considered appropriate by their clinical supervisor

• Providing professional services under the supervision of a fully qualified Supplier who reviews their work within a collegial relationship and who is competent to train and supervise others.

Their work can be invoiced as appropriate within the Service.

14.5. Allied Health Trainee health professionals

Where the trainee is unqualified and in a formal university training programme the Supplier can provide clinical experience opportunities where they consider appropriate.

Suppliers may host trainees on placement when:

• The trainee is an Allied Health Student

• The trainee is under the direct supervision of a fully qualified Service Provider who meets the qualifications, experience and supervision criteria of this contract.

With consent of the client, the trainee may sit in and observe service delivery of Concussion Services to Clients. The trainee may undertake some basic duties under supervision when directed to do so by a fully qualified Service Provider. The Supplier remains responsible for arranging the trainee’s engagement and interactions with Clients to ensure Client safety and ensuring provision of quality services. The trainee’s time cannot be invoiced for.

14.6. Psychology Student/Interns

Second Year Clinical Psychology Students/Interns may work under the Concussion contract when they are on placement from their University if they meet the supervision and induction criteria as set out on ACC’s external website.

Approval must be obtained from ACC for each individual student/intern. Email: health.procurement@acc.co.nz

14.7. Medical Registrars

Medical Registrars working under the direct supervision of a medical specialist may provide services under this contract

15. Supplier and Service Performance

Supplier performance targets are aligned with the Service Objectives and Service Requirements as set out in the Service Schedule. The key measure of success of this service is that the majority of Clients will recover and meet their agreed rehabilitation outcomes such as returning to school, work and their everyday lives.

ACC recognises that some Clients may not experience a full recovery or achieve all their rehabilitation goals but this does not necessarily mean that the Supplier has failed in providing appropriate and quality services to the Client.
15.1. Supplier Performance Measures

Supplier’s performance will be measured on:

- Client Outcomes
- Service Quality
  - Service provision in relation to Client complexity
  - Staff qualifications, training, skills and experience
- Timeliness of Service Delivery
- Involvement and coordination of the interdisciplinary team as appropriate to client need
- Any other information ACC considers relevant.

Suppliers will keep adequate documentation which will be made available to ACC for the purposes of Supplier performance monitoring. Documentation will include client clinical notes, interdisciplinary team meeting notes, records of staff qualifications, and evidence of compliance with the Supplier’s health and safety procedure and cultural responsiveness policies.

Table 10 - Supplier performance measures

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Description</th>
<th>Target</th>
<th>Frequency of reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Outcomes</td>
<td>Clients are returned to their usual activities of everyday life including work or school and no longer require any continued support under this contract for their brain injury</td>
<td>85%</td>
<td>6 monthly</td>
</tr>
<tr>
<td>Client Outcomes</td>
<td>Clients are provided with education (as appropriate to their injury) to reduce the incidence of re-injury</td>
<td>100%</td>
<td>6 monthly</td>
</tr>
<tr>
<td>Quality of Service Delivery</td>
<td>Client case reviews are conducted by a clinical neuropsychologist and medical specialist</td>
<td>100%</td>
<td>6 monthly</td>
</tr>
<tr>
<td>Quality of Service Delivery</td>
<td>Clients are clinically assessed by either a medical specialist or clinical neuropsychologist or both</td>
<td>40%</td>
<td>6 monthly</td>
</tr>
<tr>
<td>Quality of Service Delivery</td>
<td>Clients who are likely to develop long-term consequences, such as persisting concussion symptoms, are identified and are provided with effective interventions</td>
<td>100%</td>
<td>6 monthly</td>
</tr>
<tr>
<td>Performance Measure</td>
<td>Description</td>
<td>Target</td>
<td>Frequency of reporting</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Quality of Service Delivery</td>
<td>Services are coordinated by the key worker/coordinator to ensure the involvement of the interdisciplinary team as appropriate to Client need</td>
<td>100%</td>
<td>6 monthly</td>
</tr>
<tr>
<td>Timeliness</td>
<td>Services delivered meet the timeframes specified in this contract.</td>
<td>100%</td>
<td>6 monthly</td>
</tr>
<tr>
<td>Health and Safety</td>
<td>Evidence of compliance with the Supplier’s Health and Safety procedures, training and reporting requirements</td>
<td>100%</td>
<td>6 monthly</td>
</tr>
</tbody>
</table>

### 16. Health and Safety

The supplier will ensure that a risk management plan is in place to management any identified risks that face the Suppliers and Clients.

Health and Safety training is given to all Providers including all members of the interdisciplinary team to ensure that they are able to carry out their roles safely.

All health, safety and security risks or incidents must be reported in writing using the procedure on our website: [https://www.acc.co.nz/for-providers/report-health-safety-incidents/](https://www.acc.co.nz/for-providers/report-health-safety-incidents/)

#### 16.1. Working with clients who may pose a health and safety risk

ACC may not always have access to detailed information concerning a client’s history, but if a client has been identified as posing a risk, the case owner will be able to provide information to help you mitigate health and safety risks.

Clients who meet two or more of the following criteria are considered to pose a potential risk to safety, and will have a Care Indicator activated by ACC:

- Have continued to demonstrate intimidating and/or offensive behaviour (e.g. body language and verbal dialogue has made employees feel unsafe)
- Been abusive, verbally or in writing
- Made racist or sexist comments
- The current actions being undertaken on their claim by ACC are known to have caused, or are expected to cause a significantly negative response from the client. For example, Prosecution, Fraud Investigation, cessation of Weekly Compensation, etc.

Clients who meet any one of the following more serious criteria will also have a Care Indicator activated:

- Have been or are physically violent (this unacceptable behaviour may not have occurred directly towards ACC employees)
- Have a history of violence or aggressive behaviour, have known convictions for violence
• Made threats previously against ACC, ACC employees or agents acting on ACC's behalf
• Intimidated an employee through written abuse or verbal abuse (face-to-face or over the telephone) to the extent they felt unsafe
• Exhibited homicidal ideation.

16.2. Communication regarding care indicated clients
The case owner of a care indicated client will advise you in writing, either:
• Prior to your initial contact with the client, or
• If you are already providing services to the client, as soon as possible when ACC receives new information about client risk.
• Please report any threatening behaviour to the police immediately if you feel that it is warranted in the circumstances and advise ACC and any other parties that are at risk as soon as possible.

All threats by Clients or their representatives must be reported to ACC in writing using the online form on our website. We ask that you report these to us so that we can do our part to protect the safety of our staff and other Suppliers working with the client.

16.3. Stopping an assessment
Your safety is the highest priority and any assessment should be terminated if the Client, or their representatives cause you to feel threatened or unsafe.

Notify the Case Owner as soon as possible and fully document the reasons for the termination of the assessment in your report.

16.4. Reporting health and safety risks and incidents
Health and safety risks and incidents including notifiable events (as defined by WorkSafe); threats and other health and safety risks must be reported to ACC using the procedure and online form on our website https://www.acc.co.nz/for-providers/report-health-safety-incidents.

17. Resolving issues (escalation process)
Suppliers should contact the Case Owner in the first instance if there are any concerns or matters requiring clarification. Examples could include:
• Poor or inadequate information in the referral
• You require verbal instructions to be put into writing
• You need a change to a purchase order (e.g. more time, more services, date change)
• Prior approval is required
• Clarification of requirements, or expectations have changed
• Issues between Suppliers eg where a client is engaging in Concussion Services in addition to other services and the Client is being offered inconsistent information about their TBI.

When a Supplier raises an issue which is not able to be resolved directly with the Case Owner, it should be escalated to a Team Manager. If the issue is still not able to be resolved, the Supplier
should escalate the issue to their local ACC Engagement and Performance Manager.

Any issues which have the potential to be high risk, or involve risk or adverse event to a client, or a risk to ACC’s reputation, e.g.:

- Privacy breach
- Personal or client harm or safety issue
- Contract breach
- Media risk

The Supplier must tell ACC immediately. Please contact the:

- Engagement and Performance Manager
- Provider Helpline on 0800 222 070
- Area Leader
- Manager Health Procurement and Contracting

It is important to make contact and not just leave a message. For issues not able to be resolved using the process outlined above please refer to ACC’s website [www.acc.co.nz/resolving issues together](http://www.acc.co.nz/resolving issues together) and check the standard terms and conditions.

18. **APPENDICES**

**Appendix 1: Continuum of care model**

This continuum of care model for concussion rehabilitation management is based on the model developed by the Workers Compensation Board of Alberta, Canada. The model recognises that all Clients’ rehabilitation needs will vary significantly, even for similar accidents, therefore:

Set protocols cannot address the needs of every Client consistently, services must be able to adapt to the needs of the individual.

The Concussion Service was designed to enable the Supplier to, as soon as possible:

- identify the Client’s needs, and
- develop a rehabilitation programme that will deliver as rapid and full a recovery as possible.

The diagram below is a representative example of the Concussion Service in action and the approximate timeline indicates that treatments do not need to be sequential. Instead Suppliers can choose to give treatment therapies when it best meets the needs of the Client.
The rehabilitation time for each Client will vary and only a small percentage of Clients are likely to need all the service items shown. Many will require just the investigation and planning, whereas others may need a combination of services.
Appendix 2: Risk to recovery assessment matrix

The purpose of the risk to recovery assessment is to measure the biopsychosocial factors that may impact on the Client’s rehabilitation outcome and help to determine the amount and type of services needed for rehabilitation. The risk assessment is not a clinical report and can only be used as an indicator of any potential risk to the rehabilitation outcome. It is not be used to determine cover or entitlement to services.

There are four areas of Client rehabilitation risk:

- **Physical**
- **Psychological**
- **Work (employment)**
- **Life and social**

The highest rating from each of the four risk assessments will be recorded on the ACC884 Concussion Service Client Summary form for the Case Owner’s consideration.

<table>
<thead>
<tr>
<th></th>
<th>No/Low Risks</th>
<th>Low – Medium</th>
<th>Medium</th>
<th>Medium – High</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Psychological</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Work</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Life and Social</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Illustration showing where to record information on ACC884 section 8:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Level</th>
<th>Briefly describe the impacts on rehabilitation (attach clinical notes for details)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>insert risk rating</td>
<td>Write more detail about the risks here or attach clinical notes</td>
</tr>
<tr>
<td>Psychological</td>
<td>insert risk rating</td>
<td>Write more detail about the risks here or attach clinical notes</td>
</tr>
<tr>
<td>Employment</td>
<td>insert risk rating</td>
<td>Write more detail about the risks here or attach clinical notes</td>
</tr>
<tr>
<td>Life - social</td>
<td>insert risk rating</td>
<td>Write more detail about the risks here or attach clinical notes</td>
</tr>
</tbody>
</table>
### Areas / Flags

#### Meaning or interpretation of risk levels

<table>
<thead>
<tr>
<th>0 – No/Low Risk</th>
<th>1 - Low / Medium Risk</th>
<th>2 - Medium Risk</th>
<th>3 - Medium / High Risk</th>
<th>4 - High Risk</th>
</tr>
</thead>
</table>
| The Client does not appear to have obvious or identifiable risk to their recovery. | The Client appears to have some identifiable risk factors that are not so severe as to cause significant risk to their recovery. | The Client appears to have some identifiable risk factors but they are either:  
- not so severe as to cause significant risk to their recovery, or  
- they can be managed within the services requested. | The Client appears to have identifiable risk factors that are likely to impact on their recovery that may or may not be manageable within the services requested. | The Client appears to have significant risk factors that will impact on their recovery. | The options are to access a more complete range of services in this service in order to gain full recovery, or to refer the Client to other ACC services. |

### Physical

- Frequency of TBI injuries
- Severity of TBI injury
- Presence and severity of other physical injuries
- Physical disabilities
- Chronic illness

#### The Client has (and/or):
- never had a previous head injury
- no reported loss of consciousness or PTA
- had a minor knock to head, eg hit by cupboard door
- no other physical injuries
- no physical disability or any other health issues

#### The Client has (and/or):
- had a mild TBI over 5 years previously
- had a minor knock to the head, eg fall forward with an injury to face or side of head
- a minor physical injury that did not require any significant medical intervention
- a minor physical disability or health issues reported several previous concussions but they are unreported or there was no medical intervention

#### The Client has (and/or):
- had a mild TBI 2–5 years ago
- had a knock to the head, eg fallen onto hard surface
- sustained other injuries that required treatment but not hospitalisation and/or a minor physical injury that required some medical intervention
- moderate physical disability/health issues

#### The Client has (and/or):
- had a previous mild TBI within the last 12 months
- had several TBIs within the last 2 years
- had repeated knocks to the head during contact sports in the last 12 months, or received a high speed impact such as a fall from a moving horse, bike, cycle or MVA
- received moderate physical injuries that required hospitalisation
- severe physical disability and has good support/equipment
- has a chronic pain history with risk being increased if the Client has developed a post-injury headache and/or pain condition

### Psychological

- Pre-injury mental health diagnosis
- Post-injury alteration in mood
- Reaction of family
- Personality and coping skills
- Beliefs about the injury
- Life stressors

#### The Client has (and/or):
- no pre-injury mental health condition
- said that they do not drink or take drugs
- reported no alteration in mood post-injury
- supportive family and friends who display a positive attitude, have realistic expectations and a good understanding of the impact of the injury and the recovery pathway
- said that the accident was not traumatic in any way
- a positive personality with good coping skills
- no stressors that will impact on their recovery

#### The Client has:
- diagnosed mild mental health issue(s) or has had diagnosed mental health needs that are now fully resolved
- a mild use of recreational drugs or alcohol
- a mild alteration in mood post-injury, eg anxiety, tearfulness, irritability, frustration
- family and friends whose expectations are reasonably good but have some minor anxiety regarding the effects of TBI and the recovery pathway
- limited support from family and/or friends due to their commitments, eg they work full time

#### The Client has (and/or):
- diagnosed mental health needs that may affect their rehabilitation
- a moderate use of recreational drugs or alcohol
- mild alteration in mood post-injury, eg anxiety, tearfulness, irritability, frustration
- family and friends whose expectations are somewhat unreasonable and have some minor anxiety regarding the effects of TBI and the recovery pathway
- little or no identified support to assist them in their rehabilitation
- experienced several aspects of the accident or subsequent treatment as traumatic in nature

#### The Client has (and/or):
- significant mental health issue(s) that are under control with good support and medication
- a high use of recreational drugs or alcohol
- a moderate alteration in mood post-injury, eg anxiety, tearfulness, irritability, frustration
- self/family/friends who are placing unrealistic expectations on them to function at the pre-injury level but have been receptive to information to change
- experienced several aspects of the accident or subsequent treatment as traumatic in nature and is highly anxious, eg MVA with fatality, unprovoked assault, assault by a family member
- a highly dependant personality with no real coping skills and a very poor ability
<table>
<thead>
<tr>
<th>Meaning or interpretation of risk levels</th>
<th>0 – No/Low Risk</th>
<th>1 - Low / Medium Risk</th>
<th>2 - Medium Risk</th>
<th>3 - Medium / High Risk</th>
<th>4 - High Risk</th>
</tr>
</thead>
</table>
| The Client does not appear to have obvious or identifiable risk to their recovery. | The Client appears to have some identifiable risk factors that are not so severe as to cause significant risk to their recovery. | The Client appears to have some identifiable risk factors but they are either:  
- not so severe as to cause significant risk to their recovery, or  
- they can be managed within the services requested. | The Client appears to have identifiable risk factors that are likely to impact on their recovery that may or may not be manageable within the services requested. | The Client appears to have significant risk factors that will impact on their recovery. The options are to access a more complete range of services in this service in order to gain full recovery, or to refer the Client to other ACC services. |
| • good coping skills but there are some minor stressors that may impact on their rehabilitation  
• sense of self-worth is largely based on their functioning at a high level and/or they have an over-compensation coping style and/or underlying high personal standards/perfectionist traits  
• the Client has a tendency to worry with underlying cognitive theme related to loss of control and/or uncertainty. They have a pre-injury history of subclinical generalised anxiety/worry/social anxiety | • moderate coping skills and there are some stressors that may impact on their rehabilitation  
• has moderate to high life stressors that are impacting on their rehabilitation | or requirements for rehabilitation, and will need support  
• significant family and social stress that is likely to impact on their recovery | |
### Meaning or interpretation of risk levels

<table>
<thead>
<tr>
<th>Areas / Flags</th>
<th>0 – No/Low Risk</th>
<th>1 - Low / Medium Risk</th>
<th>2 - Medium Risk</th>
<th>3 - Medium / High Risk</th>
<th>4 - High Risk</th>
</tr>
</thead>
</table>
| **Feedback received said we needed to recognise multiple definitions of work.** | The Client does not appear to have obvious or identifiable risk to their recovery. | The Client appears to have some identifiable risk factors that are not so severe as to cause significant risk to their recovery. | The Client appears to have some identifiable risk factors but they are either:  
• not so severe as to cause significant risk to their recovery, or  
• they can be managed within the services requested. | The Client appears to have identifiable risk factors that are likely to impact on their recovery that may or may not be manageable within the services requested. | The Client appears to have significant risk factors that will impact on their recovery. The options are to access a more complete range of services in this service in order to gain full recovery, or to refer the Client to other ACC services. |

#### Work

**Activity is defined as work, occupation or study**

- Activity demands
- Perception of the place of activity
- Social supports at the activity
- Nature of the activity
- Satisfaction with the activity
- Activity organisation

*Feedback received said we needed to recognise multiple definitions of work.*

*This description has been broadened to all activity that requires a cognitive load that could impact in the recovery.*

<table>
<thead>
<tr>
<th>The Client (and/or):</th>
<th>The Client (and/or):</th>
<th>The Client (and/or):</th>
<th>The Client (and/or):</th>
</tr>
</thead>
<tbody>
<tr>
<td>is maintaining their pre-injury activities with low level of stress</td>
<td>is managing pre-injury activity hours but is struggling due to symptoms and/or a stressful situation with the activity</td>
<td>is managing reduced hours at activity with support of organisation</td>
<td>is unable to participate due to the severity of their injury but is keen to return to activities due to the positive environment and good satisfaction</td>
</tr>
<tr>
<td>enjoys the place of the activity and is either back participating in their activities or is keen to return as soon as they can and believes the achievement requirements are good/fair</td>
<td>is OK with the place of activity and is either back at the activity or is unexcited to return to the activity. They believe the activity requirements for achievement are realistic normally but may now be challenging</td>
<td>is anxious about their activity and is either back at the activity or is somewhat resistant to return to the activity. They believe the requirements will now be too challenging and unfair</td>
<td>has severe anxiety about returning to the activities due to a lack of organisation support. They believe the requirements are unfair</td>
</tr>
<tr>
<td>has a strong network of supportive colleagues</td>
<td>is participating in activities which they can manage their own, or which lapses in concentration and memory will not be risky or dangerous</td>
<td>has a network of colleagues in the place of activity</td>
<td>tried to return to the activity but failed and now has severe anxiety around returning to the activity</td>
</tr>
<tr>
<td>is participating in activities which they can manage their own, or which lapses in concentration and memory will not be risky or dangerous</td>
<td>has excellent satisfaction with activities</td>
<td>is participating in an activity where they have some ability to manage their own participation demands, or where lapses in concentration and memory will not be risky or dangerous, eg office worker, volunteer or student</td>
<td>has no friends in the place and people there are unsatisfactory to interact with</td>
</tr>
<tr>
<td>has a supportive organisation that is keen to participate in the immediate or gradual return to activities</td>
<td>enjoys the activities they do most of the time and has good satisfaction</td>
<td>enjoys the activities they do and has fair satisfaction</td>
<td>is in an activity where they are responsive to the needs of others and they have no ability to manage the demands, or where lapses in concentration and memory will put self and others at risk, eg machine operator, commercial driver etc</td>
</tr>
<tr>
<td></td>
<td>has a fairly supportive organisation that will provide the opportunity to participate in the immediate or gradual return to participation</td>
<td>has an organisation that will provide some opportunity to participate in the immediate or gradual return to activities, although they don’t seem overly keen</td>
<td>seldom enjoys the activities they do and does not often achieve satisfaction</td>
</tr>
<tr>
<td></td>
<td>is keen to return to the activity but feels under pressure from family to return before ready</td>
<td></td>
<td>has an organisation that requires considerable education about TBI if the Client is to make a successful graduated return to participation</td>
</tr>
<tr>
<td></td>
<td>is anxious to return to activities but perceives capacity to be higher than it is</td>
<td></td>
<td>dislikes the activities tasks they do and has never achieves any satisfaction</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>has an organisation that is not interested in participating in the Client’s return to their previous activities. They believe the Client will not be able to return.</td>
</tr>
<tr>
<td>Areas / Flags</td>
<td>0 – No/Low Risk</td>
<td>1 - Low / Medium Risk</td>
<td>2 - Medium Risk</td>
</tr>
<tr>
<td>-------------</td>
<td>----------------</td>
<td>----------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Meaning or interpretation of risk levels</td>
<td>The Client does not appear to have obvious or identifiable risk to their recovery.</td>
<td>The Client appears to have some identifiable risk factors that are not so severe as to cause significant risk to their recovery.</td>
<td>The Client appears to have some identifiable risk factors but they are either: • not so severe as to cause significant risk to their recovery, or • they can be managed within the services requested.</td>
</tr>
<tr>
<td>Life-Social</td>
<td>The Client (and/or): • lives with a supportive family environment • has no financial stress and is financially stable • lives in a stable quiet environment and is managing minimal social and leisure roles satisfactorily</td>
<td>The Client (and/or): • has moderate financial stress with available options or support for improving their situation • lives in a busy but structured household and has minimal social responsibilities • Lives in a stable environment and has responsibility for extended family/whānau</td>
<td>The Client (and/or): • has moderate financial stress with no available options or support for improving their situation • lives in a busy but structured household and has responsibility for extended family/whānau as well as several social responsibilities</td>
</tr>
</tbody>
</table>
Appendix 3: Neuropsychological assessment guidelines

Adults with mild and moderate TBI

Five hours has been allocated for the neuropsychological component of the Concussion Service. This can be seen as equivalent to a standard neuropsychological assessment in terms of time allocation.

This means that an interview should be able to be carried out as well as a reasonable amount of psychometric assessment. Clinical judgement should be exercised. Lengthy testing is not required as the Client may be in the early stages post injury where fatigue and headaches are the presenting symptoms.

A summary report is required to be shared with the multi-disciplinary team and submitted to ACC. This report is expected to be brief and is for the purpose of updating the ACC Case Owner and is not invoiced.

<table>
<thead>
<tr>
<th>Qualitative information required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident history/presenting problems</td>
</tr>
<tr>
<td>Personal background and current information</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Educational History</td>
</tr>
<tr>
<td>Occupational History</td>
</tr>
<tr>
<td>Medical History</td>
</tr>
<tr>
<td>Psychological history</td>
</tr>
</tbody>
</table>
### Forensic history (if relevant)

| Behavioural observations in assessment | Physical appearance and characteristics, ease of establishing and maintaining rapport with Client, language style, response to failures and successes, response to encouragement, attention span, distractibility, activity level, anxiety level, mood, impulsivity/reflectivity, problem solving strategy, attitude towards the assessment process, attitude toward the examiner, attitude toward self, unusual mannerisms or habits, validity of test results in view of behaviour. |

### Quantitative information required

<table>
<thead>
<tr>
<th>Estimate the Client’s…</th>
<th>pre-accident level of behavioural, emotional, and cognitive functioning and relate to the qualitative information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess the Client’s…</td>
<td>- Current behavioural and emotional functioning symptoms/performance validity, using at least one stand-alone measure of symptom/performance validity and the use of embedded measures. Please name the symptom/performance validity measures used in the list of measures administered</td>
</tr>
<tr>
<td>Test the Client’s…</td>
<td>- Attention, ie sustained, selective, alternating/divided</td>
</tr>
<tr>
<td></td>
<td>- Immediate and working memory</td>
</tr>
<tr>
<td></td>
<td>- Rate of information processing</td>
</tr>
<tr>
<td></td>
<td>- Learning and memory abilities, ie verbal and visual learning and recall.</td>
</tr>
</tbody>
</table>

### Executive functioning

Executive functioning is likely to be assessed in more detail when a Client has had a moderate rather than mild TBI. Use of everyday measures such as the Behavioural Rating Inventory of Executive Function (BRIEF) Self and Other Versions is recommended, along with formal assessment. When time constraints are present, using the BRIEF rather than formal measures of executive functioning is recommended.

### Formulation/Summary

Pulling all the sources of data together and integrating them into a coherent whole requires:

- Building on the descriptions of the presenting problems
- Summarising the performance on psychometric tests of cognitive abilities
- Combining this information with data from other sources; and
- Mapping all this onto the Client’s day to day functioning.

It is expected that pre-accident functioning in behavioural, cognitive, emotional and social domains will be taken into account when determining whether and in what ways the TBI has impacted on the Client in terms of everyday functioning. Practical recommendations should result from the neuropsychological assessment which will facilitate the rehabilitation of the Client.

It is important to identify the pre-injury and injury factors which may be impacting on and influencing a Client’s cognitive profile. A neuropsychological assessment is not, in itself, diagnostic of TBI. Pain, depression, post-traumatic stress disorder and alcohol/drug abuse can all produce cognitive deficits which
are similar to those seen in mild/moderate TBI. What is required is a consideration and analysis of all possible contributing factors and then coming to a reasoned conclusion.

**Children/adolescents with mild and moderate TBI**

<table>
<thead>
<tr>
<th>Qualitative information required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accident history/presenting problems</strong></td>
</tr>
<tr>
<td><strong>Sources of information</strong></td>
</tr>
</tbody>
</table>
| **Personal background and current information** | **Developmental history**  
• Relevant prenatal/perinatal history  
• Achievement of developmental milestones  
• Existence of developmental/learning disorders.  
**Family and Social History**  
• Family of origin - parents’ ethnicity and culture, language/s spoken at home, family makeup, quality of home environment, family stressors and family relationships  
• Social relationships – quality of friendships, sibling relationships and other social support.  
• Child’s view of self – self-concept, strengths, difficulties, hobbies and interests.  
• Client and family’s expectations of course of recovery  
**Educational History** – level of schooling achieved, academic progress, qualifications achieved, attendance record, number of changes in schools, problems and successes, relationships with teachers, attitude towards school and any special educational/behavioural interventions.  
**Medical History** – vision, hearing, illnesses, injuries, hospitalisations, medications, previous history of traumatic brain injuries, cigarette use, drug/alcohol use (current/past), pain problems, eating and sleeping habits.  
**Psychological history** – current or previous behavioural/emotional problems/diagnoses (such as PTSD, depression, anxiety), therapy (past/present), efficacy of past treatment/therapy.  
**Forensic history (if relevant)** |
<table>
<thead>
<tr>
<th>Behavioural observations during assessment and in various settings (school, playground, home)</th>
<th>Physical appearance and characteristics, ease of establishing and maintaining rapport with Client, language style, response to failures and successes, response to encouragement, attention span, distractibility, activity level, anxiety level, mood, impulsivity/reflectivity, problem solving strategy, attitude towards the assessment process, attitude toward the examiner, attitude toward self, unusual mannerisms or habits, validity of test results in view of behaviour.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quantitative information required</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Estimate the child/adolescent’s…</strong></td>
<td>pre-accident level of behavioural, emotional, and cognitive functioning and relate to the qualitative information</td>
</tr>
<tr>
<td><strong>Assess the child/adolescent’s …</strong></td>
<td></td>
</tr>
<tr>
<td>• Current behavioural and emotional functioning</td>
<td></td>
</tr>
<tr>
<td>• Symptom/performance validity, using at least one measure of symptom/performance validity and the use of embedded measures. Please name the symptom/performance validity measures used in the list of measures administered</td>
<td></td>
</tr>
<tr>
<td><strong>Test the child/adolescent’s …</strong></td>
<td></td>
</tr>
<tr>
<td>• Attention, ie sustained, selective, alternating/divided</td>
<td></td>
</tr>
<tr>
<td>• Immediate and working memory</td>
<td></td>
</tr>
<tr>
<td>• Rate of information processing</td>
<td></td>
</tr>
<tr>
<td>• Learning and memory abilities, ie verbal and visual learning and recall.</td>
<td></td>
</tr>
</tbody>
</table>

**Executive Functioning**

Executive functioning is likely to be assessed in more detail when a Client has had a moderate rather than mild TBI. Use of everyday measures such as the Behavioural Rating Inventory of Executive Function (BRIEF) Parent and Teacher Versions is recommended, along with formal assessment. When time constraints are present, using the BRIEF rather than formal measures of executive functioning is recommended.

Test interpretation requires an awareness of factors that might impact on the child’s test performance, eg family stressors (separation or other), anxiety and mood issues, distrust, sleep deprivation, lack of engagement. It’s important to identify strengths and weaknesses of the child.

**Formulation/Summary**

Pulling all the sources of data together and integrating them into a coherent whole requires:

- Building on the descriptions of the presenting problems
- Summarising the performance on psychometric tests of cognitive abilities
- Combining this information with data from other sources
- Mapping all this onto the child’s day to day functioning.

It’s expected that pre-accident functioning in behavioural, academic, cognitive, emotional and social domains and awareness of the child’s developmental stage, ie normal age variations and variability in development, will be taken into account when determining whether and in what ways the TBI has impacted on the child and their family in terms of everyday functioning. Practical recommendations should result from the neuropsychological assessment which will facilitate the rehabilitation of the child/adolescent.
**General Recommendations**

It’s important to identify the range of pre-injury and injury factors which may be impacting on and influencing a child’s cognitive profile. A neuropsychological assessment is not, in itself, diagnostic of TBI. Pain, depression, ADHD, in-utero alcohol/drug exposure, can all produce cognitive deficits which are similar to those seen in mild/moderate TBI. What’s required is a consideration and analysis of all possible contributing factors and then coming to a reasoned conclusion.

The child’s strengths and weaknesses need to be highlighted and a discussion held about how parents, teachers and the child can utilise his/her strengths to compensate for identified weaknesses.
### Version Control - Log of Changes to this document

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